

# U.S. NAVY MEDICINE

July 1979



**VADM Willard P. Arentzen, MC, USN**  
Surgeon General of the Navy

**RADM H.A. Sparks, MC, USN**  
Deputy Surgeon General

**Director of Public Affairs**  
LTJG Richard A. Schmidt, USNR

**Editor**  
Jan Kenneth Herman

**Assistant Editor**  
Virginia M. Novinski

**Editorial Assistant**  
Nancy R. Keesee

**Contributing Editors**

*Contributing Editor-in-Chief:* CDR E.L. Taylor (MC); *Dental Corps:* CAPT R.W. Koch (DC); *Education:* LT R.E. Bubb (MSC); *Occupational Medicine:* CDR J.J. Bellanca (MC); *Preventive Medicine:* CAPT D.F. Hoeffler (MC)

**POLICY:** *U.S. Navy Medicine* is an official publication of the Navy Medical Department, published by the Bureau of Medicine and Surgery. It disseminates to Navy Medical Department personnel official and professional information relative to medicine, dentistry, and the allied health sciences. Opinions expressed are those of the authors and do not necessarily represent the official position of the Department of the Navy, the Bureau of Medicine and Surgery, or any other governmental department or agency. Trade names are used for identification only and do not represent an endorsement by the Department of the Navy or the Bureau of Medicine and Surgery. Although *U.S. Navy Medicine* may cite or extract from directives, official authority for action should be obtained from the cited reference.

**DISTRIBUTION:** *U.S. Navy Medicine* is distributed to active-duty Medical Department personnel via the Standard Navy Distribution List. The following distribution is authorized: one copy for each Medical, Dental, Medical Service and Nurse Corps officer; one copy for every 10 enlisted Medical Department members. Requests to increase or decrease the number of allotted copies should be forwarded to *U.S. Navy Medicine* via the local command.

**CORRESPONDENCE:** All correspondence should be addressed to: Editor, *U.S. Navy Medicine*, Department of the Navy, Bureau of Medicine and Surgery (Code 0010), Washington, D.C. 20372. Telephone: (Area Code 202) 254-4253, 254-4316, 254-4214; Autovon 294-4253, 294-4316, 294-4214. Contributions from the field are welcome and will be published as space permits, subject to editing and possible abridgment.

The issuance of this publication is approved in accordance with Department of the Navy Publications and Printing Regulations (NAVEXOS P-35).

# U. S. NAVY MEDICINE

Vol. 70, No. 7  
July 1979

## 1 From the Surgeon General

## 2 Department Rounds

"Eagle of the Sea" or "Angel of Mercy"

## 4 Interview

The Blue Angels' Physician

## 6 Scholars' Scuttlebutt

101 Days in the Life of a Destroyer Doctor or Medicine on the High Seas

LT J.R. Fraser, MC, USNR

## 9 Independent Duty—Update

Managing the Dissatisfied Patient

CAPT J.J. Bellanca, MC, USN

## 10 Education and Training

Navy Graduate Medical Education

CDR E.L. Taylor, MC, USN

## 13 Reserve

Medical Program . . . Reservist Develops Management Information

## 14 Features

"They're Killing me!"—The Diagnosis of Occupational Disease

CAPT J.J. Bellanca, MC, USN

## 17 Navy Psychiatric Technicians in the Outpatient Setting

CDR T.G. Carlton, MC, USN

## 20 Professional

Cardiovascular Conditioning/Weight Control Program

LT G.R. Banta, MSC, USN

## 27 Notes and Announcements

## 29 BUMED SITREP

**COVER:** LCDR Charles Thomason, Blue Angels flight surgeon, and Mr. Dale Specht, representative of the McDonnell-Douglas Aircraft Corporation, watch the squadron execute a low-level pass.

---

# FROM THE SURGEON GENERAL

---

## Productivity

Are you aware that our inpatient and outpatient work loads have decreased over the past few years? Are you aware that in many instances our staffing levels are as high or higher than they were a few years ago? Yet, at the same time we all recognize and acknowledge our personnel shortages. What is the key to this paradox?

The answers are complex and routed in several factors. First, the patterns of treatment and the emphasis of health care delivery have changed dramatically. Advances in our knowledge and techniques have enabled us to shorten hospital stays and to manage many problems in an ambulatory status which previously required in-house care. A corollary has been the development of special care units so that newer, sophisticated, and far more effective modes of therapy may be dispensed.


These developments have generated great changes in both types and numbers of trained people needed in our system.

Secondly, more and more of our attention and energies have been shifted from treatment toward prevention.

These two major evolutions do in fact partially answer the question I have raised. But we must also recognize that our individual productivity has gone down. We are not unique; it is being recognized and talked about in other areas of our society today. It is a problem we should each address at all levels.

We must ask ourselves, "Can't I personally do just a little more?" Isn't it possible to use time better, to see one more patient or accomplish one more test or study? Do we utilize our appointment times to their fullest? Have we allowed our clinic and operating times to contract? Have we allowed our conference time and administrative tasks to impinge on normal direct care hours?

I think we would have to answer most of these questions in the affirmative. Efforts, both individual and corporate, will turn this trend around.

  
W.P. ARENTZEN  
Vice Admiral, Medical Corps  
United States Navy



## DEPARTMENT ROUNDS

### “Eagle of the Sea” or “Angel of Mercy”

Though nicknamed “Eagle of the Sea” and designed as an implement of war, the USS *Tarawa* (LHA-1), an amphibious assault ship, can also function as a disaster relief center for victims of a natural disaster.

*Tarawa* was the first of its class and was designed to function not only as a tactical integrity capable of getting a balanced Marine force to the same point at the same time but also to serve in a humanitarian role when needed.

The 20-story, San Diego-based ship carries a Marine Battalion Landing Force, along with the supplies and equipment needed in an assault, and lands them by helicopter and small amphibious craft.

Yet *Tarawa*’s humanitarian capabilities are among the best in the Navy today. Whether it’s a typhoon, earthquake, or flood, the 40,000-ton “Eagle of the Sea” can provide food, clothing, shelter, medical care, communications, and transportation to disaster victims.

*Tarawa* follows the long-standing Navy tradition of rendering aid when needed. As the late Fleet Admiral Chester W. Nimitz once said, “The U.S. Navy’s errands of mercy have saved more lives than its guns have ever destroyed.”

The heart of this 820-foot metallic sanctuary is its modern medical and dental facilities, among the largest afloat today.

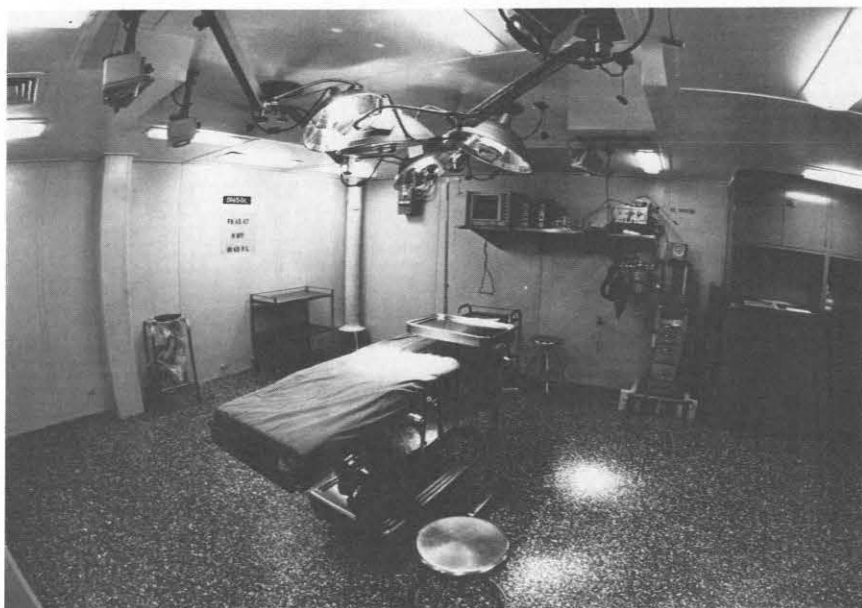
Within *Tarawa* are four operating rooms, two X-ray rooms, a blood bank, laboratories, pharmacy, physical therapy room, diet pantry, a

300-bed ward with an intensive care unit, a three-chair dental clinic, and a dental laboratory.

“The facilities are hard to comprehend for someone who doesn’t know much about medicine, but for someone who does they’re almost unbelievable,” said LT James M. Stansbury (MC), *Tarawa*’s medical officer. “This would be a major stateside hospital in a community of about 20,000 and we have most of the facilities they would have.

“We have the capabilities to handle almost any medical problem or surgery, with the exception of open heart and micro surgery,” he added.

*Tarawa*’s medical facilities were designed to handle up to 300 combat casualties or victims of a natural



One of *Tarawa*’s four operating rooms



disaster and to provide outpatient care for approximately 2,000 persons.

Though Dr. Stansbury and his staff of 15 hospital corpsmen couldn't handle the full load in event of an actual combat situation or natural disaster, they would be augmented by additional Navy medical personnel.

"Our dental facilities give us the capability to do anything a dentist in private practice can do," said LCDR Bruce E. Schindles (DC). "It's got totally up-to-date equipment and it's very easy to reach in dental surgeries."

Under normal conditions the dental facilities are manned by Dr. Schindles and four dental technicians.

*Tarawa's* first opportunity to demonstrate her humanitarian cap-



*Hospital corpsmen inventory their medical supplies.*



*Dr. Schindles (left) works on a patient in one of *Tarawa's* up-to-date dental chairs.*

abilities occurred during her initial Western Pacific deployment with the U.S. Seventh Fleet. The ship aided more than 400 Vietnamese refugees transferred to them from the frigate *USS Robert E. Peary* (FF-1073) after their rescue in May.

"It was probably one of the more rewarding things I have been involved with during the deployment," said Dr. Stansbury. "When you render aid, people don't care what your politics are. You're helping them and they're grateful," he added. "That's what's so rewarding—it's priceless."

The refugee's berthing area soon turned into a maternity ward with the birth of a baby girl, the first baby born on a *Tarawa*-class ship. The baby was delivered by HM2 Richard E. Reed assigned to the embarked Marines.

"He called me about 3 a.m., but by the time I got there he had done all the work," said Dr. Stansbury.

Appropriately, the baby was named Grace *Tarawa* Tran.

—Story and photos by JO1 James R. Giusti

## INTERVIEW

# The Blue Angels' Physician

*Since 1946, the Blue Angels Flight Demonstration Squadron has ably represented Navy and Marine Corps aviation before millions of spectators around the world.*

*The squadron is manned by 15 officers and 74 enlisted personnel. The demonstration pilots are highly trained tactical jet pilots with many thousands of hours flying experience. They also are masters of low altitude tactical maneuvers, performing rolls, loops, and close formation flying with equal precision.*

*They are not occasional aviators but fly almost every day, honing their skills for the 75 performances the Blues give each year.*

*The pilots and their shiny blue A-4 Skyhawks may be the stars, but keeping them healthy and flying is the job of LCDR Charles Thomason, who became the Blue Angels' new flight surgeon this past April.*

*Dr. Thomason is a soft spoken 32-year-old Oklahoman and a graduate of Oklahoma State University and the medical school of Oklahoma University. Before joining the Navy in 1977, Dr. Thomason interned in Spokane, Wash., and practiced general medicine in Glasgow, Mon.*

*U.S. Navy Medicine talked with him before a recent Blue Angels performance at Andrews Air Force Base, Md.*

**USNM:** When you think of the Blue Angels, you think of a highly trained and elite group of pilots, physically and psychologically in

**peak condition. As their physician, what kinds of medical problems do you encounter?**

**LCDR Thomason:** The most frequent things are colds, gastrointestinal disturbances—types of maladies that really have little to do with overall physical condition. I also treat those minor injuries that go along with athletics.



LCDR Thomason

**Do you often encounter conditions peculiar to aviation such as burst eardrums or change of altitude problems?**

Occasionally we encounter barotitis or barosinusitis but these pilots have a great deal of experience and they know how to handle problems associated with a cold. Seldom do I run into serious problems.

**You have a C-130 support plane that flies with the team. What type of medical equipment do you have aboard?**

We have three first aid kits; two are standard medical issue and the third has an assortment of required bandages as well as convenience items like suntan oil, Kaopectate, decongestants, etc.

**How much do you rely on the local community for medical support during a performance?**

All the military fields have helicopters, ambulances, and crash crews. Civilian show sites generally have crash crews and ambulances on a standby basis.

**Do you have any special duties to perform during the performances?**

Yes. I have to monitor and evaluate the pilots' performance. I listen to the cockpit communications and look for particular changes or increases in stress. One of the reasons for having a flight surgeon with the group is to monitor psychological profiles. Hopefully he can benefit the whole operation from an accident prevention standpoint.

**Speaking of stress, the risks involved in high speed aviation are evident. The style of flying these men are accustomed to is obviously more exacting and dangerous. Are they affected by this stress?**

They fly the same routine almost daily and develop tolerance to it. You're right about it being more hazardous. However, the important thing is not that their job creates stress as much as that stress may affect their job.



*Six Blue Angel Skyhawks roll down the runway for takeoff.*

**It seems as though you have to be as much a psychologist as a physician to deal with this problem. Were you adequately trained to deal with stress?**

The NAMI (Naval Aerospace Medical Institute) flight surgeon program touches the problem in some depth, particularly as it affects aviators.

**What is the NAMI flight surgeon program?**

It's basically a wide-based review of different specialties, mostly ENT, psychiatry, cardiology, aviation physiology, and several other areas relating to aviation.

**Are you an aviator yourself?**

A civilian aviator, yes. I used to do a fair amount of flying but I won't have much time now.

**What do you and the team do in your off hours, what few you have?**

I'm starting to catch up on the medical journals and I'm doing a lot of other reading.

Often there are many other commitments at show sites. On our recent tour of the west coast, every other night meant a dinner or reception. The demonstration pilots and some of the enlisted personnel also talk and lecture at schools and civic clubs in the mornings prior to flying. Often these ancillary duties are more stressful on a day-to-day basis than the actual flying.

**What kind of physical conditioning do the pilots undergo to maintain their condition?**

Each one of the pilots runs about five or six miles a day.

**Would you call it jogging?**

No, I wouldn't call it jogging at

all. They run a pretty decent pace. I certainly can't keep up with them. Some play tennis and all are avid sports enthusiasts.

**I understand that as the Blues' flight surgeon, you also have some responsibility to the Blue Angel community or family in Pensacola. Granted that being a Blue Angel pilot is a hazardous occupation, it also must put a great deal of strain on the families. There are long separations, and the realization that someday the head of the household might not come home. Have you found this to be the case?**

Honestly, I haven't been in Pensacola long enough yet to determine that, having only joined the Blues a short time ago. But I do realize it would be beneficial to have more contact with the community and I expect to in the future.



# 101 Days in the Life of a Destroyer Doctor or Medicine on the High Seas

LT James R. Fraser, MC, USNR

"What was it really like?" Since returning from a Mediterranean deployment, where I served as Squadron Medical Officer for Destroyer Squadron Twenty, I've been asked this question dozens of times by my cohorts, anxious interns, and Navy Health Professions Scholarship Program medical students. The curiosity and concern are easily understood; last year at this time, I was asking the same question.

While serving as a first-year Family Practice Resident at NRMC Charleston, I was informed that I would be required to serve in an operational billet before continuing with my residency. To say the least, I was not initially overjoyed with the news, as I had planned on completing residency before beginning practice as a Navy Family Practitioner. However, as the internship year wore on, and I began to grow weary of every third night on duty, I honestly began to look forward to my new assignment.

After completion of internship, I jumped from the world of institutionalized medicine to the world of medicine at sea. Following a three-day orientation course for prospective ship's doctors, I flew from Norfolk to Augusta Bay, Sicily, where I joined my new command and its flagship, the USS *Dewey* (DDG 45).

My new command, Destroyer Squadron Twenty, consisted of two DDG's (Guided Missile Destroyers), a DD (destroyer), and three fast frigates, or more aptly put for those of you who know as much as I did at the time, six L.G.B.'s (large grey boats).

My duties as Squadron Medical Officer (SMO) were somewhat atypical in the sense that I had medical responsibility for not just one ship, but a squadron consisting of six ships. However, as I spent the majority of my time aboard the flagship, I think my experiences were similar to those of any other sea-going medical officer. In general, my responsibility as SMO was to advise the Commodore concerning the health, hygiene, sanitation, and safety affecting the squadron, and to care for the sick and injured. My feelings when I arrived were probably typical of any young physician with such a new set of responsibilities; I wondered if I would be able to handle them. In retrospect, I think any well-trained and motivated medical officer can indeed fulfill those responsibilities.

To give you some idea about the facilities I had to work with, I'll describe the USS *Dewey's* medical department. It was amazingly small, about 8' x 8'. It contained a fold-down examining table, small desk, small refrigerator, surgical sink, and an autoclave. On shelves above and below were stocked the most commonly used pharmaceuticals, intravenous solutions, and parenteral medications. The room would be filled to capacity with but one patient and two other persons working therein. It was often uncomfortably warm and was always noisy. Any patients waiting to be seen had to stand outside in a narrow passageway. The other squadron ships had similar medical departments.

As you might expect, the laboratory capability was extremely limited. We could spin down hematocrits, had kits for doing mono spots and RPR's, and had a microscope with which to look at urine specimens, gram stains, etc. No radiology equipment was available. We did have a portable defibrillator which, fortunately, we never had to use.

---

This article is an edited version of a talk presented at the Surgeon General's Graduate Medical Education Workshop on 17 Jan 1979 to the Workshop attendees and the BUMED staff.

LT Fraser has extended with COMDESRON 20, FPO New York 09501.



The types of illnesses and injuries we saw ran the gamut, but as you would expect, most were the simpler maladies well within the competence of any doctor. In decreasing frequency, they were:

- U.R.I. and viral syndrome complaints
- Acute and chronic orthopedic complaints, including low back and other muscular strain
- Skin disorders, including scabies, tinea, cellulitis, abscesses, impetigo, folliculitis, acne, and non-specific rashes
- Gastrointestinal complaints
- Headaches
- Soft tissue trauma including minor burns and lacerations requiring suture
- Behavioral problems including psychological counseling and/or evaluation for substance abuse
- Genito-urinary and other complaints secondary to sexually transmitted diseases
- Physical exams

Three patients were med-evaced during my three and a half months at sea, one for repeated suicidal gestures, one for marked depression, and one for acute hepatitis.

One of my important duties was the preventive aspects of shipboard medicine. This initially caused me some apprehension. I didn't remember courses in med school on food and water quality, temperature and ventilation, barbershop and scullery operations, or cockroach control. These are indeed important subjects, and a medical officer can learn about them from orientation, his predecessor, and from the manuals. However, my own best source of knowledge was the excellent Chief Corpsman aboard the *Dewey*.

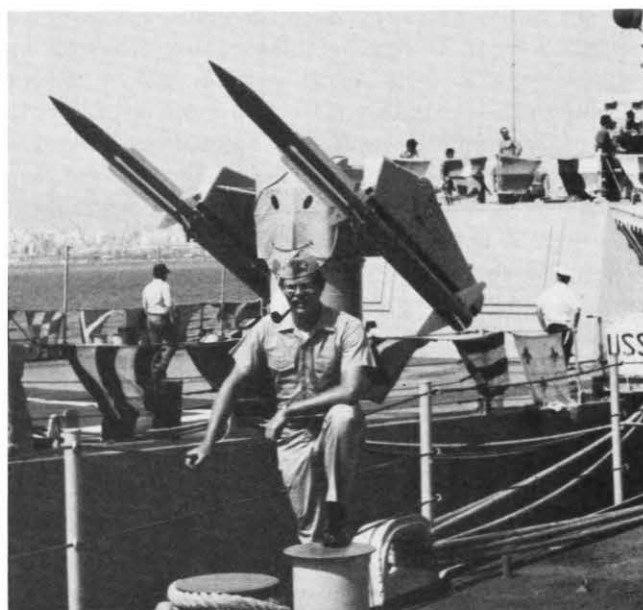
The actual performance of these preventive and sanitation duties is assumed by well-trained and knowledgeable corpsmen. The medical officer supervises quality control and interprets and communicates his findings to the appropriate command in order that appropriate preventive or corrective action can be taken.

In terms of actual man-hours spent with patients, the most time was spent on psychological assessment and counseling. The stresses of life and work aboard ship, made worse by extended deployment, separations, and immature personalities created many situations that the medical department had to deal with. Many sick-call complaints were secondary to these underlying psychological stresses. The medical department provided the necessary catharsis, counseling, and encouragement, and served as a significant morale booster for the crew.

Another one of my jobs was to educate the corpsmen, stretcher bearers, and the ship's crew. All ships have

requirements for training in topics such as first aid, nuclear, biological, and chemical warfare decontamination, preventive health measures, substance abuse, and sexually transmitted diseases. A medical officer's knowledge and interest provides real impetus for the instruction of these topics.

Even though there is always the possibility of medical crisis aboard any deployed ship, the medical services I provided during my three and a half months at sea most often involved the straightforward and commonplace problems well within the competence of any well-trained physician. As a result of the work environment and living spaces, traumatic injury was common, few of the injuries were life-threatening or serious, and I found my minor surgical skills adequate.



*LT Fraser*

Other skills I found most useful were general outpatient medicine, some psychological and counseling experience, a basic understanding of preventive health measures, and potentially most in demand, a knowledge of initial management and supportive measures for the critically ill or injured.

After spending my first 10 days at sea playing war games, we steamed into Palma de Mallorca, a beautiful Spanish island in the Mediterranean known for its beaches, castles, and its attraction to Northern European tourists. I can't think of anything I didn't like about Palma. I did, however, work hard there. Several ships that had not had access to a medical officer for months had quite a backlog of consults, physicals, psychiatric, drug abuse, and alcoholism evals. All were in

need of medical officer messing and berthing inspections. There also seemed to be an excessive number of liberty casualties as well as an outbreak of rather virulent gastroenteritis. At times, I felt like a busy intern all over again. There was time, however, for an excellent U.S.O. show with Miss America and six other talented state representatives.

After Palma, we returned to sea for nine more days of war games and I welcomed the needed rest and the time to read and relax. As I mentioned, I was busy at Palma, but being at sea was usually another matter. In general, my days were low-key, and I'd encourage any sea-going medical officer to take plenty of reading material, both medical and otherwise.

A typical day would be to rise between 0700 and 0800. Breakfast in the wardroom was ready much earlier, but as I almost always read late, I slept late to make up for it. During breakfast, I would answer my message traffic. This is how a good deal of medical consultation is handled with corpsmen on the other ships or with EPMU-7 in Naples. Consultations are also conducted via ship-to-ship phone when ships are close enough or by coded teletype when they are out of range and there is some urgency.

I would then drop by sickbay for consultation. I'd often talk with the corpsman at that time about various medical topics.

Lunch was at 1130. In the afternoon, after completing any physical exams or scheduled appointments, I'd usually go up to the 05 deck to catch some sun, read, or play chess or scrabble. Dinner was an event not to be missed aboard the *Dewey*, where the meals as with most squadron ships, were generally good to excellent.

At 2000 movies were shown in the wardroom. During and after movie hours, I also got to know the Commadore, Captain, and Chaplain well.

Getting to know the officers and men aboard ship was a real pleasure. It's easy in our profession to become almost exclusively involved in medically oriented social circles. It was enlightening to get to know others and talk about their interests and their work. I found that if you show interest in what your shipmates are doing, they will bend over backward to explain it to you. In this way, I learned a smattering about navigation, operations, weapons, and engineering. I had heard somewhere that line officers were antagonistic toward the Medical Corps. I found that not to be the case. On the contrary, I felt my presence and contributions were very much appreciated.

On those occasions when my presence was required aboard the other ships, I was treated royally. Getting there, however, especially during rough seas, is another experience. Transfer is usually by helicopter

rather than by small boat. This does not mean they land to pick you up and land to let you off. Instead, they snatch you from the ship's fantail by hoist with a horse collar stuck beneath your arms. While hovering 30 to 40 feet above you, they sometimes start you spinning as they're hosting you up. Getting lowered from a pitching and rolling helicopter onto a pitching and rolling deck is also highly recommended for relieving boredom.

Our next liberty port was Barcelona, Spain. The following 18 days were some of the most memorable of my life. My wife had made arrangements to fly over and meet me. After making arrangements for potential emergency coverage, we began an odyssey through Spain and France, including eight days in Paris. Suffice it to say that it was a wonderful opportunity and we had the time of our lives.

After 18 days of upkeep, the ship left Barcelona and returned to sea for still more war games. By this time, I had become a hard-core stargazer and had learned to identify the major constellations. On a clear night with calm seas, one can truly say there is something about being at sea that's soothing to the psyche.

Our last liberty port was Monaco on the French Riviera. Monaco was superb and we were treated as guests with free admission arranged at the casinos, museums, and golf and tennis clubs. We were able to return the favor when over 50 of the *Dewey's* crew donated blood to ease a local shortage.

After six days in Monaco, we again went to sea for our final round of war games and this time were accompanied by 15 to 20-foot seas for about three days. This was a time I'd just as soon forget, but I'm sure I won't. It also provided for some of my best sea stories. Trying to suture a laceration or start an I.V. while trying to hold onto something stationary to keep from being bashed into the bulkhead is an interesting challenge. We all survived, however, though some of the superstructure of the ship did not.

Finally, we departed Rota, Spain, and steamed a leisurely 12 days across the Atlantic to Charleston.

In retrospect, I look back to all the new experiences I had while deployed, and realize that I probably would never have had them hadn't I been required to go operational. I have no regrets. There is no doubt that the experience has helped me become a better Navy doctor.

Despite the fact that many Navy doctors are repelled by the idea of serving aboard ship, I would encourage them to personally experience what makes "Navy" for the Navy physician. Deployment is not only a challenge in an alien environment with limited space and resources. It is also an opportunity for personal and professional enrichment and a once-in-a-lifetime chance to see "what it's really like."

# Managing the Dissatisfied Patient

CAPT Joseph J. Bellanca, MC, USN

**T**he best way out of difficulty is usually through it. Lost medical records, prolonged waiting periods, medication errors, appointment delays, and unsatisfactory treatment results are common sources of dissatisfaction which make patients angry and damage important therapeutic relationships. Distraught patients can seriously disrupt the smooth operation of a medical care facility, and in some cases, lead to malpractice situations. All of us know things can go wrong and, as long as you are the one on the firing line, you are the one who has to set them right. Don't make excuses, prove you understand, and never belittle. These are the three basic rules.

The most important rule is the one on excuses. If ever there is a time to think positively, it's when the patient is hopping mad. The good approach in this situation is to keep in mind that this is an oppor-

tunity to demonstrate "patient care!"

The best bet is to see the patient as soon as possible and listen to his or her story. Maybe you feel the complaint is unjustified, but never say so, and don't give the impression that you think he is making a mountain out of a molehill. To him it's a very important matter.

Listen to the complete story without interrupting. After he blows his top, he should be in a better frame of mind. Also, by letting him talk until he has finished his complaint, you get the facts. You can't find a satisfactory solution without them.

When the unhappy patient has told you why he is dissatisfied, prove that you understand his complaint by repeating it as you understand it. This gives the patient the opportunity to correct any false conclusions which you may have reached. The other important advantage of you repeating the story is that it gives the patient an opportunity to see the complaint in a different light. Often, he ends up agreeing that the matter is not as important as it appeared to be when he first

became aware that something was wrong.

Probably your first reaction to a patient complaint is "What's he all excited for? A lot worse things happen everyday." Maybe so, but to this patient, at this particular moment, this incident is very important. That's why you must never belittle his perception. Sometimes it is even helpful to inflate the importance of the complaint, almost to a point of exaggeration. Ask for more details by explaining that the more you know about the situation, the better prepared you'll be to prevent it from happening again. If you don't overdo it, which can make him think you are ridiculing him, you may soon hear the patient say, "Oh, it's not so bad as your making it out to be." Then he is helping you find an equitable solution.

In summary, the three important principles in handling complaints well are: don't make excuses, prove you understand, and never belittle. Satisfactory complaint handling proves you really care. Always do what is right; it will gratify some people and astonish the rest.

---

From the Department of the Navy, Bureau of Medicine and Surgery (MED 3142), Washington, D.C. 20372.

---

## EDUCATION & TRAINING

---

# Navy Graduate Medical Education

CDR E.L. Taylor, MC, USN

The 11th Surgeon General's Specialties Advisory Committees' (SAC XI) Conference will convene in the Washington, D.C. area 9-14 Sept 1979. The purpose of this conference is primarily to review all Graduate Medical Education (GME) applications and nominate selectees for Navy GME to the Surgeon General. The SAC XI Conference will perform many other functions during this convening, i.e. discuss issues related to GME, review teaching staff projections, exchange ideas and philosophies, and make formal recommendations to the Surgeon General and his selected panel of advisors.

### Graduate Medical Education Availability

The Navy offers 33 GME training programs in 8 teaching medical centers. Four are multidisciplinary and four are Family Practice Training Hospitals:

#### *Multidisciplinary*

NNMC Bethesda, Md.  
NRMC Oakland, Calif.  
NRMC Portsmouth, Va.  
NRMC San Diego, Calif.

#### *Family Practice*

NRMC Charleston, S.C.  
NRMC Camp Pendleton, Calif.  
NRMC Jacksonville, Fla.  
NARMC Pensacola, Fla.

Individual Navy GME programs and the number of positions available in each program for 1980-1981 are listed in Table 1.

Applications should be forwarded to:

Commanding Officer  
Naval Health Sciences Education & Training Command  
(ATTN: Code 4)  
National Naval Medical Center  
Bethesda, Md. 20014

*Deadline for receipt of all applications - 15 Aug 1979*

### Interviews

Personal interviews with program director are strongly encouraged. Expenses incurred for interviews are the responsibility of the applicant.

### Selection Process

Each specialty committee reviews appropriate applications and makes recommendations for selection to the Surgeon General who has sole and final approval authority. As a guide to past selection rates, see Table 2.

### Selection Priorities

The following priorities will continue to be used to select qualified applicants for all GME programs:

#### *First Priority*

Presently serving in an operational/utilization tour.

#### *Second Priority*

Incumbent GME1 (interns) with significant previous active duty.

#### *Third Priority*

Incumbent GME1 (interns) with no previous active duty. (Active duty, in the Uniformed Services University of the Health Sciences, is not in itself, considered as a priority).

#### *Fourth Priority*

Inactive reserve

#### *Fifth Priority*

Civilian applicants

These priorities assure the qualified applicant, who is serving in an operational/utilization tour, usually after his GME-1 year, an excellent chance for returning to the specialty training of his choice. This SAC XI committee will not only recommend selection of 1980 GME trainees, but will be strongly encouraged to recommend selection of trainees for 1981. Outyear selection numbers will be guided by priorities set within the Bureau of Medicine and Surgery. This will, in certain cases,



**TABLE 1: Residencies/Fellowships in Naval Activities Indicating Positions at Each Year Level by Activity**

		Years of training offered	Number of positions each year	Bethesda	Camp Pendleton	Charleston	Jacksonville	Oakland	Pensacola	Portsmouth, VA	San Diego	Other
Aerospace Medicine	*	3	6						6			
Anesthesiology	*	2	20	6				4		4	6	
Dermatology	*	3	8	3							5	
Family Practice	*	2	38		9	9	12		8			
Hand Surgery		1	1								1	
Internal Medicine and Subspecialties	*	3	30	6				4		8	12	
Cardiology		2	6	2							4	
Endocrinology & Metabolism		2	3	2				1				
Gastroenterology		2	3	1							2	
Hematology/Oncology		3	4	2							2	
Infectious Disease		2	4	2							2	
Nephrology		2	1								1	
Pulmonary Disease		2	4	1						1	2	
Neurology		3	3	3								
Neurosurgery	*	4	1	1								
Nuclear Medicine		2	3	2				1				
Obstetrics & Gynecology	*	3	18	3				3		6	6	
Maternal Fetal		2	1	1								
Occupational Medicine	*	3	1									1
Ophthalmology	*	3	9	4				2			3	
Orthopedic Surgery	*	4	12	2				3		3	4	
Otolaryngology	*	4	10	2				3		2	3	
Pathology	*	4	10	3				2		2	3	
Hematopathology		1	1	1								
Pediatrics	*	3	18	3				3		6	6	
Plastic Surgery		2	1							1		
Preventive Medicine (General)	*	3	1									1
Psychiatry	*	3	11	4				3		4		
Radiology	*	3	17	6				3			8	
Surgery	*	4	13	3				2		4	4	
Peripheral Vascular Surgery		1	1								1	
Thoracic & CV Surgery		2	2	1							1	
Urology	*	4	6	1				1		2	2	

\*Indicates numbers of years training beyond GME year one.

**TABLE 2: GME (Residency and Fellowship)  
Statistics SAC X, Sept 1978**

Status	Applicants	Selected	Percent Selected
Resident (For Fellowship)	29	23	79%
Incumbent Intern	183	71	39%
Operational/Utilization*	210	135	63%
Inactive Reserve	31	3	10%
Other Military	3	1	33%
Civilian	63	9	14%
Total	519	242	46%

\*The term "Operational/Utilization" encompasses all primary care medical officers applying or reapplying for GME from a nontraining status.

preclude the necessity for reapplication on the part of the incumbent intern required to serve in an operational tour prior to GME-2 and will guarantee placement two years in advance.

#### Notification Date

Following adjournment of SAC XI, and an internal Bureau review, the Surgeon General will conduct a final review and approve committee selection recommendations according to the needs of the Navy. Advance notice of selection, alternate or nonselect status may not be divulged until the Surgeon General has officially approved the slate of nominees.

As soon as possible after approval of the Surgeon General, (approximately 15 Oct 1979) applicants will be notified of the SAC XI results via letter.

#### Responsibility of Applicant After Notification

The official notification will include information as to selection, alternate, or nonselection status, and a service training obligation agreement. Selectees are required to notify the Naval Health Sciences Education and Training Command of acceptance or declination within 10 days of receipt of the notification. Failure to respond will result in the position being offered to another qualified candidate.

#### Outservice Training

Each year a limited number of individuals are selected for full-time outservice training in civilian in-

stitutions. These specialties are determined by the Bureau Advisory Board and are placed in an order of priority according to the critical needs of the Navy Medical Department. For the SAC XI Conference, the following priorities have been established for outservice training:

#### *Priority Specialty/Subspecialty Listing for Full-Time Outservice Training*

- (1) Specialty and subspecialties of Orthopedic Surgery
- (2) Aerospace Medicine
- (3) Critical Care Medicine
- (4) Emergency Medicine
- (5) Surgical subspecialties
  - a. Plastic Surgery
  - b. Neurosurgery
  - c. Pediatric Surgery
- (6) Subspecialties of Internal Medicine
  - a. Rheumatology
  - b. Nephrology
  - c. Tropical Medicine
  - d. Infectious Disease
  - e. Allergy/Immunology
- (7) Occupational Medicine
- (8) Preventive Medicine
- (9) Stress Physiology
- (10) Underwater Physiology
- (11) Physical Medicine
- (12) Rehabilitation Medicine
- (13) Ophthalmology subspecialties
- (14) Pediatric subspecialties
- (15) Obstetrics/Gynecology subspecialties
- (16) Psychiatric subspecialties

NOTE: No. 5 and No. 6 receive equal consideration

Applicants for full-time outservice training are responsible for seeking and being accepted by the civilian institutions. The application process for full-time outservice training is identical to the inservice procedure and applicants are considered at the annual SAC Conference. No commitment from either the Navy or the applicant can be made until the SAC committee recommendations have been received and have been reviewed for final approval by the Surgeon General.

#### *Application Process (Inservice and Outservice)*

BUMED Instruction 1520.10G of 12 May 1976, provides necessary guidance to those medical officers applying for graduate medical education.

Specific information regarding training programs may be obtained by contacting the appropriate depart-

ment chairmen at the regional medical centers. Addresses of the teaching hospitals are listed below:

Commanding Officer  
National Naval Medical Center  
Bethesda, Md. 20014

Commanding Officer  
Naval Regional Medical Center  
Oakland, Calif. 94627

Commanding Officer  
Naval Regional Medical Center  
Portsmouth, Va. 23708

Commanding Officer  
Naval Regional Medical Center  
San Diego, Calif. 92134

Commanding Officer  
Naval Regional Medical Center  
Charleston, S.C. 29408

Commanding Officer  
Naval Regional Medical Center  
Camp Pendleton, Calif. 92055

Commanding Officer  
Naval Regional Medical Center  
Jacksonville, Fla. 32214

Commanding Officer  
Naval Aerospace and Regional Medical Center  
Pensacola, Fla. 32512

For general information regarding any questions you may have, HSETC is always available to assist you in any way possible. Best wishes to each and everyone of you in pursuing your Graduate Medical Education endeavors.

CDR E.L. Taylor, MC, USN  
Director, Medical Corps Programs  
Naval Health Sciences Education &  
Training Command (Code 4)  
National Naval Medical Center  
Bethesda, Md. 20014  
Phone: 295-0648/9

RADM A.C. Wilson, MC, USN  
Commanding Officer  
Naval Health Sciences Education & Training Command  
National Naval Medical Center  
Bethesda, Md. 20014

---

## RESERVE

---

### MEDICAL PROGRAM

The Chief of Naval Operations has approved the transfer of Program 9—Marine Corps Forces Selected Reserve billets currently authorized for the First, Second, and Third Marine Amphibious Forces to Program 32. These billets are being utilized to reconstruct Naval Regional Medical Center Units similar to those which existed prior to implementation of "Project Readiness." There will be approximately 101 units nationwide ranging in size from 3 officers/20 enlisted to 6 officers/27 enlisted, whose mobilization sites will be at selected Naval Regional Medical Centers. This action, which is expected to be implemented by 1 Oct 1979, will increase female corpsmen opportunities for Reserve participation and will restore one of the most popular and successful programs that we have had in the Naval Reserve. As a result of the billet transfer, future Marine Corps mobilization requirements will be met by using active duty manpower resources. Existing Fourth Marine Division/Air Wing units will be retained. However, a few of these units will be relocated in order to achieve an equitable distribution throughout each Naval Reserve Readiness Command.

### RESERVIST DEVELOPS MANAGEMENT INFORMATION

During the month of May, the Medical Service Corps Division benefited from the active duty training service of LCDR Susan Haberkorn, MSC, USNR-R. With training and previous active duty experience as a physical therapist, LCDR Haberkorn holds a Master's degree in Public Health and is currently working toward a doctorate at the University of Michigan. She represents outstanding professional talent among our Naval Reserves. Previous active duty training for this officer has included such vital assignments as CINCLANTFLT staff. LCDR Haberkorn is currently drilling with A-R5 VULCAN Detachment 613. Consequently, she is well-versed on matters of fleet support. During this particular two-week period, LCDR Haberkorn developed the framework of a management information system for the Medical Service Corps Naval Reserve component, working closely in so doing with CAPT William Narva, MC, USN and LCDR Al Donohue, MSC, USN of the BUMED Naval Reserve Special Assistant's office.

# “They’re killing me!”

## The Diagnosis of Occupational Disease

CAPT Joseph J. Bellanca, MC, USN

In 1803, Lord Nelson stated, “The great thing in all military service is health, and you will agree with me that it is easier for an officer to keep men healthy than for the physician to cure them.” The Medical Department exists to keep our Navy and Marine active forces healthy. Each and every health professional can contribute to this important effort by identifying occupational health problems caused by hazardous work environments and initiating appropriate corrective actions.

Bernardo Ramazzini, in the 1700’s, advised physicians about carefully questioning patients about occupation. He recognized that characteristic illnesses developed in certain trades. Through visits to the workplace, he was able to suggest precautions to prevent these illnesses. His observations about the connection between illness and occupation are still valid today.

Disease often results from the unhealthy encounter of an individual with the physical, chemical, and social environment. Since adults spend 30 to 50 percent of their time in a work environment, familiarity with that environment is essential for diagnosis and proper treatment.

Occupational diseases are specific diseases brought on by certain dose exposure to work hazards. For ex-



From the Department of the Navy, Bureau of Medicine and Surgery (MED 3142), Washington, D.C. 20372.

*Some jobs could involve exposure to more than one hazard. Grinding old paint may cause exposure to lead dust and excessive noise.*



ample, silicosis is a specific industrial-related lung disease with definite clinical characteristics caused by the inhalation of minute airborne sand particles. It results from a significant dose of inhaled dust particles within a respirable size range. Silicosis is caused neither by granular sand nor silicone (a plastic), nor does it develop in someone exposed to sandblasting for only five minutes. This may seem fairly evident, yet physicians sometimes unthinkingly accept a worker's claim that "that stuff I breathe at work is killing me!" These claims are frequently based on subjective distortions of toxicology. Workers often believe foul smelling chemicals are the most dangerous. In reality, foul odors may be harmless (sour milk), odorless exposures may be fatal (carbon monoxide), and foul smells may be fatal (hydrogen sulfide).

The diagnosis of occupational disease is made in the same painstaking manner as nonoccupational disease. The physician must carefully consider the patient's medical history and then perform physical examination, and laboratory and radiological evaluations to confirm initial clinical impressions. To determine whether an illness is caused or aggravated by work, consideration should be given to other important factors.

The occupational history is important for establishing past exposures to potentially hazardous substances and the degree of such exposure. Toxic exposures can occur on any job. It is insufficient to ask a person's job title and then assume their job is not hazardous. A clerk-typist may regularly use solvents containing trichloroethylene or benzene to clean the typewriter, or a dentist may grind potentially dangerous beryllium-containing metal on a daily basis. You may understand what a carpenter does, but it is more valuable to know that he is



*Portable air sampling devices can be used to measure a variety of workplace air contaminants for comparison with established safe levels.*

frequently exposed to loud noise, and that he cuts asbestos cement board with a power saw without dust control or respiratory protection. Don't assume the use of protective devices—ask specific questions. Workers are not likely to volunteer information when they are negligent in following required safety procedures.

When evaluating an illness of occupational origin, one must go beyond those exposures occurring in the present job. Past exposures to potential health hazards may be equally significant. Interstitial fibrosis identified on a chest X-ray may have had its origin in the dusty environment of a previous job. The X-ray changes of asbestos exposure sometimes takes 20 years from initial exposure until the radiographic manifestations of the disease become evident.

You must identify the specific substances handled, the *intensity*, route, and duration of exposures,

the protective clothing used by the worker, and the engineering controls employed. Most potentially toxic materials to which a worker is exposed in his occupation are inhaled, but the skin and the gastrointestinal tract may also be routes of entry. Workers exposed to lead dust may ingest it when they eat in the workplace without first washing their hands properly. Many solvents can be absorbed systemically when spilled on the skin or clothes.

Individual workers may give very different descriptions of the same exposure, either exaggerating or minimizing, depending upon personal beliefs and motives. Useful data can often be obtained from the supervisor or the safety manager and other individuals familiar with the workplace and the patient's job. The presence or absence of similar effects or signs or symptoms of disease in fellow workers sharing essentially the same environment is important and useful. (It is also helpful to know if someone at home has a similar illness).

If monitoring devices or air sampling techniques have been used to evaluate the working environment, the analytical results should be obtained and compared to accepted standards such as the ACGIH Threshold Limit Values. Textbooks, journals, and public health authorities are promptly available for consultation by the physician unfamiliar with these procedures and standards.

In acute poisoning, specific tests for the quantitative determination of the suspected material or one of its metabolites in the blood, urine, or breath should be done promptly if they are available. Hematological, biochemical, or other tests likely to indicate absorption or particular effects of a toxic agent should be carried out. However, the mere presence of a particular compound in an elevated concentration in a



*Work involving hazardous exposures should not cause illness when proper precautions are employed.*

certain organ or tissue of the body does not necessarily indicate that an intoxication has taken place. A laboratory chart indicating that "blood lead levels above the normal value of 30 ug/100 ml are toxic" is misleading. The normal blood lead value reflects lead that is ingested or inhaled as part of our normal environment. Elevated blood lead suggests increased lead exposure, and when above 80 ug/100 ml in adults, warns of the possible onset of lead neuropathy. The significance

of elevated concentration of a toxic substance in body fluids must be carefully evaluated in terms of accumulated medical knowledge. Repetition of a specific test after discontinuation of exposure may provide additional important information.

Certain individuals in the work population have increased susceptibility to some chemical exposures. Medications, allergies, smoking, and alcoholism are all factors which can interact with otherwise safe levels of environmental contami-

nants to produce disease. The toxicity of ethylene dibromide is increased in workers taking Antabuse. Teflon dust is not toxic except when it contaminates cigarettes to cause "polymer fume fever." Allergy-prone individuals may be particularly at risk in work environments where certain allergenic chemicals such as isocyanates are used. The aging worker may also be at special risk.

Occupational disease may be mimicked by nonoccupational disease. A common example is the occurrence of abnormal liver function studies in workers exposed to potentially hepatotoxic chemicals. Although experienced physicians recognize that heavy alcohol ingestion is clearly the most frequent cause of liver dysfunction in the working population, occupational exposures are often overlooked.

Detrimental exposures may also occur away from work. The moonlighting worker or one who has a hobby involving potentially hazardous materials may be endangered. A welder protected by excellent exhaust ventilation at his daily worksite may ignore all precautions while welding at another job. The home itself may not insure a safe environment. The most frequent cause of acute arsenic poisoning in this country is a homicidal spouse.

Diagnosis should be based on mature consideration of all the findings by history and clinical examination. This is particularly so in the case of occupational disease because other workers may also be involved. If you suspect an unsafe workplace, you should contact the appropriate public health officials. They will conduct environmental and epidemiological studies and recommend the hygienic and engineering practices for remedying hazardous situations. Prevention is the best cure.

# Navy Psychiatric Technicians in the Outpatient Setting

CDR Thomas G. Carlton, MC, USN

The recent drastic reductions in Navy psychiatric manpower have tended to focus attention on more efficient means of delivering mental health services. One long overlooked resource is the Psychiatric Technician (NEC 8485).

The Army, the Air Force, and many civilian mental health centers have long recognized a broad role for mental health technicians.<sup>(1-6)</sup> The Army, for example, has schools to train technicians for outpatient work (including psychological and social work skills) and for the administrative aspects of military psychiatry. Our fellow services have assigned mental health technicians to independent duty with indirect psychiatric supervision, apparently with considerable success. These technicians have been able to provide mental health services where they would otherwise be unavailable.<sup>(1,2,5)</sup>

Macht<sup>(7)</sup> has pointed out the need for a viable career ladder and opportunities for paraprofessionals. There is currently no such career ladder for Navy mental health technicians. Shortly after promotion to HM2 (E-5), the technician is usually afforded no option but to leave psychiatry and/or the Navy. A common "reward" for senior technicians has been to remove them from the clinical setting. Anyone closely associated with Navy psychiatry is painfully aware of the low reenlistment rate for these technicians.

Navy psychiatric technicians, unlike those of the other services, are trained only for inpatient work. Indeed, they are the only technicians listed together with general duty ward corpsmen (NEC 0000) in a recent report on the Navy Occupational Task Analysis Program.<sup>(8)</sup> Navy psychiatric technicians are expected to be assigned to nursing units and their billets are generally assigned on the basis of inpatient statistics alone, with no consideration of outpatient loads. When psychiatric wards of a facility have been closed, the

technicians have often been reassigned to nonpsychiatric duties either on medical wards or in such areas as transportation, special services, and laundry. This has been true even at facilities with heavy psychiatric outpatient loads.

A number of recent factors have combined to begin to change the role of the technician in Navy psychiatry. Among these factors have been:

- The drop in the number of Navy psychiatrists, which appears to be with us for some time.
- The increased pressure to keep patients out of the hospitals.
- The increased expectation that Navy psychiatry should provide a broader range of services, along the lines of mental health centers.
- The recently increased importance of physician extenders in all fields of medical care.
- The apparent poor morale among Navy psychiatric technicians who have become aware that their's is a deadend job.
- The recent re-recognition among many Navy psychiatrists that Navy psychiatry is largely community, consultative, preventive, and industrial psychiatry.

In response to these and other factors, a number of Navy psychiatry departments have begun to use technicians more and more in the outpatient setting. These changes have generally been very well received by the technicians and psychiatrists involved. The response from commands, the patients, and referral sources has been favorable, as it has been in the past for the Army.

Often these changes have initially been brought about somewhat *sub rosa* in spite of the wealth of favorable experience, as though they were somehow illicit. Even with the hesitant starts, the results of these changes have been encouraging. The author has had personal experience with utilization of psychiatric technicians at two quite different commands which can serve as examples.

---

CDR Carlton is assistant chief of Psychiatry for Outpatient Psychiatric Services, NRMCC Portsmouth, Va. 23708.



## Example 1

In 1974 through most of 1975, the Naval Regional Medical Center, Camp Lejeune, N.C., had a fairly classical psychiatric outpatient clinic with two psychiatrists and a psychologist seeing new outpatients at the center hospital. Patients were scheduled for a standard psychiatric hour and there was a six- to eight-week wait for active duty appointments. There were also two outlying clinics operating somewhat similarly. The average inpatient load was around 45 patients on two wards. Essentially all these patients were local admissions, with almost no medevacs.

In 1975 and early 1976, the psychiatry department went through a period of "experimentation" to attempt to shorten the waiting time for appointments and to reduce admissions.

The psychiatric clinic obtained two psychiatric technicians for outpatient work. These were experienced senior technicians who screened all first-visit patients through questionnaire and interview. The technician then arranged for the patient to spend an appropriate amount of time with the psychiatrist or psychologist. A block appointment system was used, with groups of patients arriving and beginning their paperwork at the same time. Technicians on the inpatient wards were also trained to do basic intake interviews on emergency room patients. This provided an onboard watchstander with mental health training who could see patients in crisis at night and on weekends and work out followup arrangements with the on-call psychiatrist.

With these changes, emergency referrals were much less disruptive; the average waiting list time was reduced from more than six *weeks* to within two working *days* for first-visit evaluations. The number of "no-shows" dropped markedly. Most surprisingly, the admission rate dropped dramatically. Over a period of several months, the average census dropped to less than one-third of what it had been. This seemed to represent primarily a decrease in those admissions precipitated by impulsive behaviors in response to frustration. It appeared that one major factor in the changes observed lay in an increased ability to provide supportive contact earlier, either in the emergency room or in the clinic, and that without the technicians these changes would not have been seen. This is admittedly anecdotal data and the cause and effect relationship is conjecture, but it is compatible with the Army experience. (1)

## Example 2

The Naval Regional Medical Center, Portsmouth, Va., has also faced a problem of providing timely care,

but it has faced the additional problem of providing local care throughout a farflung and heavily populated region. It is an accepted axiom of military psychiatry that most acute problems can be handled better, with more likely restoration to duty, if they are treated rapidly and near "the front" (in this case the ship, squadron, or shore command). It is very difficult to provide adequate service to people who must travel 25 miles or more and take at least half a day off from work for each appointment.

Using psychiatric technicians in a manner similar to that described above for Camp Lejeune, Portsmouth has established four psychiatric clinics in strategic locations throughout the region, with each clinic being responsible for specific catchment populations. These clinics have relied very heavily upon psychiatric technicians to enable them to provide timely, local services. Indeed, three clinics are staffed only by a technician at some time during the week.

The technicians serve primarily as intake interviewers, but they have also been used quite successfully in a number of other areas, including:

- Emergency evaluations and crisis intervention.
- Administration of questionnaires and psychological tests.
- Supportive counselling.
- Referral to other appropriate sources such as counselling and assistance centers, chaplains, social service agencies, Navy Relief, etc.
- Command and agency consultations including visits to ships in port.
- Training nonpsychiatric corpsmen in basic mental health skills, particularly interviewing.
- Participation in contingency-oriented crisis intervention teams.

Obviously good supervision is a vital part of the program, with each technician being supervised by a mental health professional (psychiatrist, psychologist, or psychiatric social worker) who is responsible for that technician's work.

There have been very few problems or complaints. Considerable praise for the technicians has been heard from outside the psychiatry department, and line commands have been very happy to be receiving prompt, local service. The only impediment encountered to date has been that of making enough experienced technicians available for outpatient work. This difficulty stems at least partly from current assignment policies, inpatient needs, and nursing service controls over technicians.

Portsmouth is now in the process of establishing a



local program to train experienced psychiatric technicians in outpatient work.

## Discussion

In view of the increasing demands on Navy psychiatry and the decreased numbers of Navy psychiatrists, technicians have become more important both in the day-to-day operation of clinics and in contingency planning. Increased utilization of psychiatric technicians in the outpatient setting has even facilitated some expansion of services in the face of dwindling psychiatric staff. This use of psychiatric technicians may prove particularly helpful in small clinics where a single psychiatrist or psychologists must provide all the mental health support for a Navy or Marine Corps community.

The potential effect of these and similar programs on retention rates among psychiatric technicians is also worthy of consideration. Such programs could form the foundation for a viable enlisted career ladder within the mental health field. The opportunity for advancement and more independent work within the field might encourage more psychiatric technicians to remain on active duty beyond their initial obligations. The existing liaison with the Army training programs could be expanded to provide the advance training needed for such a career ladder to work.

In summary, psychiatric technicians are a long neglected and highly valuable resource that can be utilized to extend the reach and expand the services of Navy psychiatry even in the face of present constraints.

## References

1. Glass AJ: Mental Health Programs in the Armed Forces, in *American Handbook of Psychiatry*, 2nd ed. Edited by Ariefi S. New York, Basic Books, 1974, Vol II, pp 800-809.
2. Glass AJ, Artiss K, Gibbs JJ, et al: The Current Status of Army Psychiatry. *Am J Psychiatry* 117:673-683, 1961.
3. Bey DR, Smith WE: Mental Health Technicians in Vietnam. *Bull Meminger Clin* 34:363-371, 1970.
4. Gartner A, Reissman F: The Performance of Paraprofessionals in Mental Health Fields, in *American Handbook of Psychiatry*, 2nd ed. Edited by Ariefi S. New York, Basic Books, 1974, Vol II, pp 826-836.
5. Nolan KJ, Cooke ET: The Training and Utilization of the Mental Health Paraprofessional Within the Military: The Social Work/Psychology Specialist. *Am J Psychiatry* 127:114-119, 1970.
6. Rodeman CR, Seidenfeld MA, Rockmore MJ: The Technicians, in *Neuropsychiatry in World War II*. Edited by Anderson RS. Washington, Office of the Surgeon General, Department of the Army, 1966, pp 701-717.
7. Macht LB: Community Psychiatry, in *The Harvard Guide to Modern Psychiatry*. Edited by Nicholi AM. Cambridge, Harvard University Press, 1978, p 646.
8. Burkhardt FA: NOTAP Collects HM Data. *US Nav Med* 69(6): 11, June 1978.

## Protecting Your Prescriptions

Recently, physicians—and, particularly, those new in private practice—are being approached by persons exhibiting varying extremes of drug-seeking behavior. Identifying these patients can become a problem; however, there are several clues which can alert you to the possibility that a patient may be a drug misuser/abuser:

- when an unfamiliar patient tells you that a controlled product he wants from you was previously prescribed for him by another physician (either in private practice or in a hospital) who is currently unavailable
- when an unfamiliar patient states that he is the patient of another physician for whom you may occasionally cover and

wishes a prescription for a controlled product renewed

When either of these situations occurs, it is a good idea to ask the patient for the name of the physician or hospital and attempt to verify the story. If the patient tends to avoid answering your questions, it generally indicates a problem. Often with this type of patient, your prescription blank is the prime target. The following are some suggested guidelines to follow to insure its safety and proper use.

1. Store all unused prescription pads in a safe place where they cannot be easily stolen.
2. Minimize the number of pads in use at one time.
3. Have prescription blanks numbered consecutively when

printed so that you can tell if some sheets are missing.

4. Never sign prescription blanks in advance.

5. Write prescriptions in ink or indelible pencil to prevent changes.

6. Write out the actual amount of medication prescribed in addition to using an Arabic or Roman numeral—this discourages alterations.

7. Do not use your prescription blanks for writing notes or memos which can be erased and the blanks used again.

8. Do not leave prescription pads in unattended examining rooms, office areas or in your bag or car where they can be easily picked up.

—Reprinted with permission of Roche Laboratories

# Cardiovascular Conditioning/ Weight Control Program

LT Guy R. Banta, MSC, USN

This article describes a cardiovascular conditioning/weight control program currently in use at Naval Air Station Meridian, Mississippi. It is hoped that it will influence the development of similar programs or that the methods described will be utilized by any facility, physician, clinical counselor, physiologist, dietitian, etc. involved with cardiovascular conditioning and weight control programs.

The development of coronary heart disease (C.H.D.) is well known throughout the world. In the United States alone the annual death toll due to C.H.D. has been reported to reach near 600,000. (1) Of the patients seen at the Cardiovascular Conditioning/Weight Control Clinic, Meridian during the last 18 months, 41.2 percent related a family history of C.H.D., 19.4 percent related a personal history of some form of underlying C.H.D., and 19.8 percent had abnormal blood pressures. The factors associated with C.H.D. are well known—hypertension, hypercholesterolemia, arteriosclerosis, smoking, excessive emotional stress, elevated uric acid, inactivity, and obesity.

Obesity is not a new problem, but in the past few years the Navy has begun to express substantial interest in the weight status of Navy personnel in relation to performance of duty and personal appearances. (2,3,4,5,6) At Meridian, the number of naval personnel seen for weight problems only scratches the surface of those in the Navy and Marine Corps in need of health and administrative guidance (Table I). Of the 352 patients examined, the average weight needed to be lost equalled 33.5 lbs/individual. The method by which the needed weight loss was determined will be explained later.

If an individual is over the maximum allowable weight level in reference to his height, should he be? If not, what is the optimal weight between the minimum and maximum weight levels for best health? Even though the individual is under the maximum allowable weight, should that weight be even lower when the

**TABLE I: Subjects Seen at the Cardiovascular Conditioning/Weight Control Clinic**

Total seen (past 18 months)	352
Active Duty (Officer and Enlisted)	301
Dependents	39
Retired	12
Males	235
Females	117

weight is considered in relation to body structure and musculature when evaluating performance capability and military appearance? Once these questions are answered, a weight control program that will enable an individual to lose the required weight in a sensible manner has to be developed.

## Types of Evaluations

The Cardiovascular Conditioning/Weight Control Program handles several types of requests:

- Voluntary request for weight evaluation by members who feel they need to lose or gain weight.
- Requests by command and/or department supervisors of military personnel to verify compliance with current Navy/Marine Corps weight standards.
- Referrals from medical department personnel for weight evaluation, specific diets, coronary rehabilitation programs, counseling, and exercise programs.
- Voluntary requests by individuals for physical fitness status evaluations.

**TABLE II: Abnormal Blood Chemistries**

A. Cholesterol	21.7%
B. Triglycerides	27.6%
C. Glucose	2.5%
D. T4	1.69%

LT Banta is a naval aerospace physiologist assigned to NARMC Branch Clinic, Naval Air Station, Meridian, Miss., as an aeromedical safety officer with additional duty to Training Air Wing One.



*Stress ECG can be conducted with a treadmill or a Master's Two Step profile.*

### Laboratory Analysis

Once an individual has been given an appointment at the Cardiovascular Conditioning/Weight Control Clinic, he is instructed to fast 12-14 hours prior to the evaluation. This is to insure the accuracy of a blood analysis that will be conducted the day of his appointment. Epidemiologic studies reported in the literature continually provide evidence of the possible direct proportion of C.H.D. risk with elevated serum cholesterol and serum triglycerides. (7,8,9) In the interest of determining indications of possible underlying disorders that may cause or aggravate hyperlipidemia and/or exogenous obesity, it is vital to do a complete fasting SMAC and thyroid (T4) and evaluate all blood chemistries. A summary of the abnormal lab results on our subjects has revealed the following (Table II).

### Electrocardiogram

A 12-lead resting ECG is conducted on all personnel over 30 years of age as a standard procedure. For any individual under 30 years of age with a significant personal history of ECG abnormality, C.H.D., or elevated BP, a resting and/or closely monitored stress ECG, can be conducted if a cardiologist and a crash cart are available. A stress ECG conducted with a treadmill or a Master's Two Step profile (Figure 1) on a normal individual is also a good index of physical fitness level. It allows the recording of the individual's submaximum heart rate during stress. This fitness level and submaximum heart rate determination can help determine a proper cardiovascular exercise program by using the submaximum heart rate as a monitor. (This is described in the exercise section of this paper.)

### Anthropometric Measurement

Unfortunately, the Navy has fallen into the insurance company mold of using mean height/weight charts for determining allowable weight for naval personnel. The instruction promulgating the Navy's latest height/weight chart indicates that appropriate medical facilities will determine whether an individual belongs within the minimum-maximum range or whether he can exceed the maximum allowable weight. In order to use this chart effectively, determine what the subject's ideal weight should be for good health, and to fulfill the Navy's maximum allowable weight, complete and accurate body measurements must be taken.

The best method of body composition determination is by the human body volumeter on displacement of water. (10) However, even without this equipment, anthropometric and skin fold measurements have resulted in noteworthy "high multiple condition coefficients and low standard errors of estimate." (11) The process involves the use of appropriate calipers (Figures 2, 3). The resulting measurements are then used in a series of multiple regression equations. The results yield an ideal target weight at a recommended relative fat percentage (Tables III and IV). (11,12,13)

### Exercise

During the interview session each subject is provided a short educational program on the coronary system and basic physiology. This enables him to understand his own body and why the program must be followed as designed. After discussing the basic benefits of exercise i.e., reduced blood pressure, increased stroke volume, lowering of serum triglycerides, and weight loss, the subject is told about exercise at the submaximum heart rate. (14)



**TABLE III: Multiple Regression Equations**

a. Wright E. Wilmore, 1974 (Simple field test) (15)

Lean body weight (kg) =  $40.99 + 1.035(\text{weight (kg)}) - 0.6734(\text{abdominal circumferences (cm)})$ . (S.E.E. = 3.49)

(NOT RECOMMENDED FOR FEMALES)

b. Wilmore & Behnke, 1968 (13)

LBW - the square of the results of the sum of two torso measurements plus two extremity measurements divided by the sum of their conversion factors times the individual's height:  $(2TM + 2E^*M/2TM_D)^2 \times \text{height (dm)} = \text{LBW}$ .

Measurements (diameters (cm))

Conversion Factors (D)

- 1) Biacromial (T)
- 2) Bideltoid (T)
- 3) Chest (T)
- 4) Bi-iliac (T)
- 5) Bitrochanteric (T)
- 6) Knee (E)\*
- 7) Ankle (E)\*
- 8) Elbow (E)\*
- 9) Wrist (e)\*



- 21.3
- 24.4
- 15.5
- 14.7
- 17.3
- 9.7
- 7.2
- 7.1
- 5.9

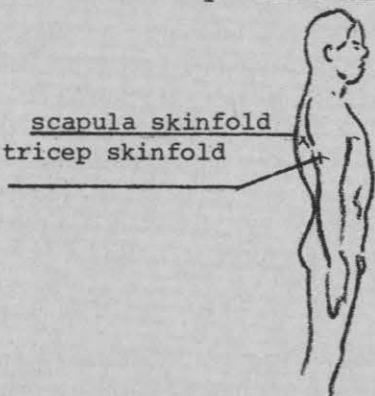
\* Sum of right and left sides

% body fat =  $\text{present weight (kg)} - \text{LBW (kg)} / \text{present weight (kg)}$

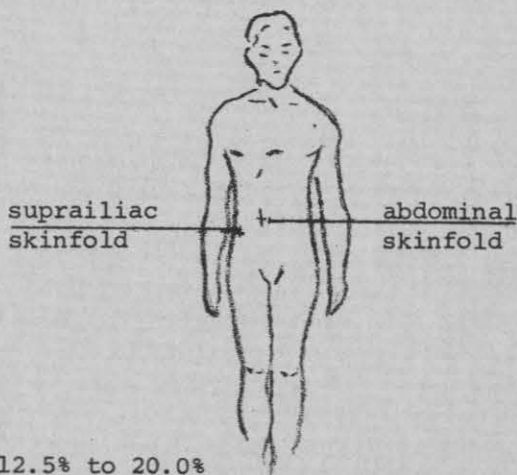
c. Wilmore & Behnke, 1969 (14)

% body fat =  $5.783 + .153(\text{triceps skinfold} + \text{scapula skinfold} + \text{abdominal skinfold} + \text{suprailiac skinfold})$

scapula skinfold  
tricep skinfold



suprailiac skinfold abdominal skinfold



d. Ideal relative fat % range = 12.5% to 20.0%

Recommended target weight can be calculated by dividing the actual lean body weight (LBW) by that fraction which represents the ideal lean body weight.  $1.000 - .125$  (if 12.5% relative fat is desired) = 0.875 or target weight =  $\text{LBW} / 0.875$ .



**TABLE IV: Example Calculation**

Individual #1

Height: 17.02 dm

Weight: 93.98 kg

Skinfolds

Suprailiac: 25.2 mm

Abdomen: 40.2 mm

Scapula: 38.6 mm

Triceps: 21.2 mm

W & B:  $5.783 + .153(21.2 + 38.6 + 40.2 + 25.2) = 24.9\%$  body fat

Anthropometry

Biacromial: 40.0 cm

Chest: 33.2 cm

Bicristal: 33.7 cm

Ankle: 7.3 cm

Wrist: 5.5 cm

Bideltoid: 60.0 cm

Bitrochanteric: 34.6 cm

Knee: 11.1 cm

Elbow: 8.8 cm

W & B:  $40.0 + 33.7 + 2(7.3) + 2(5.5)/49.1 = (2.02)^2 \times 17.02 =$   
 69.61 kg LBW.  $93.98 - 69.61/93.98 = 25.9\%$  body fat  
 12.5% relative fat desired =  $69.61/.875 = 79.56$  kg. Ideal weight = 175 lbs

NOTE: Skinfold measurements should be used as a verification of accuracy when compared to the anthropometric measurements.

The subject is then encouraged to follow one of the full body movement type exercise programs—walking, jogging, running, swimming, cycling, basketball, etc. This exercise regimen provides the coronary system sufficient stress at or near 65-80 percent of maximum heart rate for 15-20 minutes four days a week. The subject is taught to monitor his carotid pulse in order to insure that the submaximum heart is being maintained during exercise. (A common way to determine maximum heart rate is to subtract the individual's age from 220 BPM. For calculation of submaximum heart rate, use the equation:  $220 \text{ BPM} - \text{age} \times .65$  or  $220 \text{ BPM} - \text{age} \times .80$ ). Allowing the individual both to perform the exercise of his choice and monitor himself is a positive bio-feedback mechanism. Endurance and strength increases. Metabolic, cardiovascular, and respiratory functions improve, and weight loss is achieved. Table V lists the percentage breakdown of preferred exercise programs by our subjects.

**TABLE V: Exercise Program Selection**

Event	Percentage
Jogging/Running	47.7%
Walking	15.6%
Cycling	9.6%
Racquetball	3.1%
Rope Jumping	2.3%
Swimming	1.1%
Basketball	.8%

**TABLE VI: Cardiovascular Conditioning/Weight Control Check List**

Age: \_\_\_\_\_ yrs  
 Ht: \_\_\_\_\_ ins  
 Wt: \_\_\_\_\_ lbs  
 Frame: \_\_\_\_\_ slender

B/P: \_\_\_\_\_  
 RPR: \_\_\_\_\_  
 Maximum allowable weight: \_\_\_\_\_ lbs  
 medium \_\_\_\_\_ heavy \_\_\_\_\_ obese

**Skinfolds**

Chest: \_\_\_\_\_ mm  
 Thigh: \_\_\_\_\_ mm  
 Abdomen: \_\_\_\_\_ mm

Biceps: \_\_\_\_\_ mm  
 Triceps: \_\_\_\_\_ mm

**Circumferences**

Neck: \_\_\_\_\_ cm  
 Shoulder: \_\_\_\_\_ cm  
 Chest: \_\_\_\_\_ cm

Abdomen: \_\_\_\_\_ cm  
 Hips: \_\_\_\_\_ cm

**Diameters**

Biacromial: \_\_\_\_\_ cm  
 Chest: \_\_\_\_\_ cm  
 Bicristal: \_\_\_\_\_ cm

Bideltoid \_\_\_\_\_ cm  
 Bitrochanteric \_\_\_\_\_ cm  
 Knee \_\_\_\_\_ cm

Ankle \_\_\_\_\_ cm  
 Elbow \_\_\_\_\_ cm  
 Wrist \_\_\_\_\_ cm

Lean body weight: \_\_\_\_\_ kg  
 Fat weight: \_\_\_\_\_ kg  
 Relative fat: \_\_\_\_\_ %

Ideal (Target) Body weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg

**Lab**

Triglyceride: \_\_\_\_\_ mg%  
 Cholesterol: \_\_\_\_\_ mg%

T3/T4: \_\_\_\_\_  
 Fasting Glucose: \_\_\_\_\_

Last Physical: \_\_\_\_\_  
 ECG: \_\_\_\_\_ Date \_\_\_\_\_  
 Family History: \_\_\_\_\_

Exercise: \_\_\_\_\_ day/wk \_\_\_\_\_ min./day  
 at heart rate of \_\_\_\_\_ BPM

Diet: \_\_\_\_\_ Calories

	BREAKFAST	LUNCH	DINNER
Vegetables: _____			
Breads: _____			
Meats: _____			
Milk: _____			
Fruits: _____			
Fats: _____			

**WEIGH IN:**

1st week _____ lbs date _____	11th week _____ lbs date _____
2nd week _____ lbs date _____	12th week _____ lbs date _____
3rd week _____ lbs date _____	13th week _____ lbs date _____
4th week _____ lbs date _____	14th week _____ lbs date _____
5th week _____ lbs date _____	15th week _____ lbs date _____
6th week _____ lbs date _____	16th week _____ lbs date _____
7th week _____ lbs date _____	17th week _____ lbs date _____
8th week _____ lbs date _____	18th week _____ lbs date _____
9th week _____ lbs date _____	19th week _____ lbs date _____
10th week _____ lbs date _____	20th week _____ lbs date _____



*Calipers are used for anthropometric and skin fold measurements.*

## Diet

There are probably 10,000 or so diet plans on the market and about as many people promoting them. The one that outshines the others and is most highly recommended by the medical community for weight reduction, weight gain, and maintenance of weight, is the balanced diet with the reinforcement of a moderate exercise program.<sup>(15)</sup>

To lose weight, calories burned must exceed caloric intake. This is what is achieved in a combined diet and exercise program. Patients are encouraged to achieve a weight reduction at a rate no greater than approximately 1-1.5 kg per week average (2 to 3 lbs). This prevents sacrificing muscle-mass (strength and endurance), helps retain the body's metabolism to adjust to normal state, and helps maintain the individual's motivation.<sup>(16)</sup> A negative caloric balance can be achieved by reduction of the balance input by 1000-1500 calories/day but never to a level less than a total of 1500 calories input for adult males or 1200 calories for adult

females.<sup>(17)</sup> A number of ingenious methods exist to determine what the individual's present daily caloric input is at his/her present weight.<sup>(18)</sup> One of the simplest, is to multiply the individual's present weight by (x15) and reduce accordingly 1000-1500 calories.<sup>(17)</sup> Table VI, in addition to listing the subject's total work-up, will reveal a recommended balanced diet plan. By placing the maximum servings allowed in the blank spaces corresponding to the food groups and meals allows the individual to design his own meal plan. The equating of the servings to be placed on the diet sheet and a list of the available food is also provided.<sup>(19)</sup> However, if the laboratory analysis and other medical evaluation reveal dangerous levels of cholesterol, triglycerides, thyroid imbalance, other abnormal blood chemistries, underlying C.H.D., hypertension, etc., specific diets and/or medications might be necessary until a level of acceptance can be achieved. Only then can the individual be allowed to continue on a "balanced" diet/no medication program.

However, medication usually will not inhibit participation in the basic diet/exercise program. In fact, participation is essential.

## Conclusion

The program has a success rate of 76 percent based on the number of participants who have reached or are continuing toward their goals. This high success rate can be attributed both to the scientific approach of diet/exercise programming and the positive motivation developed in each individual that comes to the clinic. This positive motivation and continued effort by the patient is not as difficult to achieve as many feel. What it takes is what we all desire, individual attention. With the massive numbers of people in need of medical guidance and with the shortage of medical staff, it is easy to pull out the height/weight chart, give out a pre-printed diet plan and tell people to lose weight. Our plan may take more time, but we are achieving success with a professional approach to a Navy-wide problem. The subject usually feels obligated to give us as much effort as we give him. His education about health maintenance for himself and his family is substantially enhanced.

The individualized approach of this program is further enhanced by weekly monitoring of weight loss, bimonthly interval laboratory analysis, and ECG's. Encouragement of supervisors or commands to acknowledge the individual's participation and success on evaluations also seems to help.

Similar programs in the Navy should be developed. The need is there. In order for U.S. Navy and Marine Corps personnel to remain healthy and maintain themselves at a level of peak performance, the commitment to this kind of health maintenance is essential.

## References

1. Cooper KH, Pollock ML, et al: Physical Fitness Levels vs Selected Coronary Risk Factors. A cross sectional study. *JAMA* 236: 116-169, 1976.
2. BUPERSMAN 3420440 of Jan 1978. Weight Control Policies and Procedures of Administratively Handling Obese Personnel. Bureau of Naval Personnel, Wash., D.C.
3. BUPERSINST 6110.2B of Oct 1976. Weight Control: Guidelines and Responsibilities. Bureau of Naval Personnel, Wash., D.C.
4. BUPERSNOTE 1616 of Dec 1977. Reporting of Individual Height and Weight Status on Enlisted Performance Evaluations. Bureau of Naval Personnel, Wash., D.C.
5. Manual of the Medical Department Weight Standards for Navy and Marine Corps Personnel. Physical standards, articles 15-17, 1978. Bureau of Medicine and Surgery, Department of the Navy, Wash., D.C.
6. Marine Corps Order 6110.36 of 23 Sept 1975: Physical Fitness, Weight Control and Military Appearance. Headquarters, Marine Corps, Wash., D.C.
7. Margolis S: Treatment of Hyperlipidemia. *JAMA* 239:2696-2698, 1978.
8. Lees RS, Lees AM: Therapy of the Hyperlipidemia. *Post Grad Med* 60:99-107, 1976.
9. Kannel WB, Castelli WP, Gordon T, et al: Serum Cholesterol, Lipoproteins, and the Risk of Coronary Heart Disease. *Ann Intern Med* 74:1-12, 1971.
10. Allen TH: Measurement of Human Body Fat: A Quantitative Method for Use by Aviation Medical Officers. *Aero Med* Oct 1963.
11. Wilmore JH, Behnke AR: Predictability of Lean Body Weight Through Anthropometric Assessment in College Men. *J Appl Physiol* 25:349-355, 1968.
12. Wilmore JH, Behnke AR: An Anthropometric Estimation of Body Density and Lean Body Weight in Young Men. *J Appl Physiol* 27:25-31, 1969.
13. Wright HF, Wilmore JH: Estimation of Relative Body Fat and Lean Body Weight in a United States Marine Corps Population. *Aero Med* 301-306, March 1974.
14. Exercise Testing and Training Apparently Healthy Individuals: A Handbook for Physicians. American Heart Association, New York, 1975.
15. Fribers H (ed): Weight Control: Advising Patients About Fad Diets. *Patient Care* 78-104, June 1976.
16. Smith NJ: Gaining and Losing Weight in Athletics. *JAMA* 236: 149-171, 1976.
17. Allsen PE, Harrison JM, Vance B: Fitness for Life. An Individualized Approach. WC Brown Co, Dubuque, Iowa, 1975.
18. Lamar SR: Human Energy Requirements: A Simple Tool for Assessment in a Weight Control Program. *US Nav Med* 67(6):22-25, June 1976.
19. Daily Menu Guide. Eli Lilly and Co, Indianapolis, Ind., 1972.



---

# NOTES & ANNOUNCEMENTS

---

## IN MEMORIAM

*Leonard A. Duce*, Ph.D., who for 22 years gave faithful and dedicated leadership and service to the Federal medical services, died on 9 June 1979 in San Antonio, Tex., at age 70.

Born in Princeton, Ontario, Canada on 26 May 1909, Dr. Duce received a Bachelor of Arts degree and his Theological Training at McMaster University, Hamilton, Ontario. From 1931 to 1942, he served in pastorates in Ontario, Massachusetts, and Connecticut. He began his career in education in 1943 at William Jewell College, Liberty, Mo., where he was Professor of Philosophy and Dean. In 1946, he received a Ph.D. from Yale University and then joined the faculty at Baylor University as professor and chairman of the Department of Philosophy. During the 11 years at Baylor, he became more involved in education administration serving as Assistant Dean, Associate Dean, and ultimately as Dean of the graduate school. From 1960 to 1974, Dr. Duce held the position of Dean of the graduate school and Professor of Philosophy and Business Administration at Trinity University. In 1976, after 19 years of service as a lecturer, he became the Director of the Interagency Institute for Federal Health Care Executives.

The Interagency Institute was initiated 27 years ago by the Federal medical services to provide an organized means of developing professional management among the various agencies responsible for the delivery of medical care under Federal Government sponsorship. It has continued to provide a two-week course conducted semiannually under the sponsorship of the Departments of the Army, Navy, Air Force, Public Health Service, and the Veterans Administration. Under Dr. Duce's leadership, the Institute's focus on providing a forum for the sharing of experience among all the Federal health agencies increased significantly. He brought to the directorship the talents of a superb educational administrator who was energetic and insightful in his approaches to program improvement.

*CAPT Philip Van Horn Weems*, USN (Ret.), a navigation researcher, died 2 June 1979 at age 90.

CAPT Weems was born in Montgomery, Tenn., and graduated from the U.S. Naval Academy in 1912. His duty assignments included the command of the USS *Hopkins* and instructor at the Navy's postgraduate school. He was the first air navigation research officer

assigned at the Naval Hydrographic Office. CAPT Weems retired in 1933, but was recalled to active duty in 1942. During World War II he was a convoy commander, an assignment for which he was awarded the Bronze Star. He retired again in 1946, but in 1961 was recalled to active duty to conduct a pilot class in space navigation. He retired again in 1962.

Following his first retirement, he founded the Weems System of Navigation, a navigation instrument and publishing company in Annapolis, Md. Many of the instruments and systems developed under his direction are still used in sea and air navigation.

CAPT Weems' first textbook, "Air Navigation," won the gold medal of the Aero Club of France in 1931. During his long career, he wrote more than 400 articles and held seven patents for navigation instruments. His awards include the John Oliver La Gorce Medal of the National Geographic Society, the Thurlow Award of the Institute of Navigation, and the Magellanic Premium of the American Philosophical Society.

CAPT Weems most noteworthy projects were the star altitude curves for celestial navigation and the development of the modern air almanac, a combination which made practical the long-range air navigation missions of World War II.

## GASTROINTESTINAL ENDOSCOPY FOR THE SURGEON

The National Naval Medical Center and the Uniformed Services University of the Health Sciences, Bethesda, Md., will sponsor a symposium on Gastrointestinal Endoscopy for the Surgeon 26-28 Sept 1979.

For further information write: CAPT L.E. Smith, MC, USN, Box 175, National Naval Medical Center, Bethesda, Md. 20014.

## ATTENTION NAVY AUTHORS

Many articles by Navy personnel appear each year in a variety of professional journals and other publications. *U.S. Navy Medicine* would like to include a monthly list of some of these articles written by Navy authors from all corps. If you have published recently and would like to share your research or perceptions with your colleagues, please send us the title, name, and issue of the publication in which your article appeared.

## WEST COAST NURSING SYMPOSIUM

This is the second year of the West Coast Nursing Symposium, presented by the Navy Nurse Corps, under the sponsorship of the Health Sciences Education and Training Command (HSETC), Bethesda, Md. The symposium will be held 1-2 Oct 1979 in conjunction with the 86th Annual Meeting of the Association of Military Surgeons of the United States (AMSUS) slated for 2-6 Oct 1979 at the Town and Country Convention Center, San Diego, Calif.

The West Coast Nursing Symposium represents an opportunity for nurses to share knowledge, ideas, skills, and fellowship. It provides nurses from many areas of expertise a forum in which to learn from leaders and each other, the opportunity to update knowledge, and to develop ideas concerning current trends in professional nursing.

The symposium will be conducted by clinical nurses on relevant topics in all areas of clinical practice. Wide use of multimedia and simultaneous sessions highlight the offerings available to the participants. The symposium aims to explore and highlight many of the contemporary issues, challenges, and opportunities of clinical nursing.

This symposium has been approved by the California Board of Registered Nursing and by HSETC for a maximum of 10 contact hours. HSETC is accredited by the Northeast Regional Accrediting Committee of the American Nurses' Association. The actual number of contact hours granted will depend on the total number of sessions attended. In order to comply with the Board of Registered Nursing requirements, registrants must attend an entire session and will be required to complete an evaluation tool. Procedures for documenting attendance at sessions and for obtaining and submitting evaluation tools will be detailed in the official program.

The entrance fee for the nursing symposium will be \$40 and also entitles participation in the AMSUS convention.

## UNIVERSITY OF CALIFORNIA COURSES

The Department of Extended Programs in Medical Education at the University of California School of Medicine will sponsor the following courses:

### *Topics in Emergency Medicine* 17-21 Sept 1979

The objective of this program is to instruct the participants *in depth* through didactic presentations, case studies, student/teacher interactions and demonstrations in the approach to problems in the emergency

department. Upon completion of this program, registrants should be more competent in handling injuries of the hand and face, in diagnosing and treating acute cardiac disease, in interpreting radiographs, and in managing problems in other areas including pediatrics, ophthalmology, neurology, and obstetrics/gynecology. Pre- and post-course assessments will be available, as will a syllabus with references.

The program meets the criteria for 40 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Certification Program of the California Medical Association. The course is also approved for 39 hours in Category I by the American College of Emergency Physicians, and is acceptable for 40 elective hours by the American Academy of Family Physicians.

### *Update in Obstetrics* 4-6 Oct 1979

This symposium will provide the most current information in obstetrics. The program is designed for clinicians involved in the health care of the pregnant woman. This program should provide concise, practical, and current clinical information concerning contemporary issues in obstetrics.

The course meets the criteria for 14 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Certification Program of the California Medical Association, and 14 cognates, formal learning, of the American College of Obstetricians and Gynecologists.

For more information write or call: Extended Programs in Medical Education, University of California, Room 569-U, Third and Parnassus Ave., San Francisco, Calif. 94143. Telephone (415) 666-4251.

## RECENT ARTICLES BY NAVY AUTHORS

*The Intra-axonal Transport of Evans Blue Albumin Within the Vagus Nerve to the Duodenum* by ENS Kevin S. Kennedy, MC, USNR and W.M. Yau. *Gastroenterology* 76:1168, May 1979.

*Cytologic Description of Squamous Cell Papilloma of the Respiratory Tract* by CDR Lawrence R. Rubel, MC, USN and HM1 Robert E. Reynolds, CT, ASCP, USN. *Acta Cytologica* 23:227-230, 1979.

## AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

The next Government Services Chapter, American College of Emergency Physicians will be held during the 1-4 Oct 1979 Annual ACEP Scientific Assembly, Atlanta, Ga.

## **SHORE ESTABLISHMENT REALIGNMENT ACTIONS NOTED**

On 1 June 1979, Shore Establishment Realignment (SER) actions become effective at four medical facilities. The four facilities affected, formerly Naval Hospitals, are new Naval Regional Medical Clinics and have ceased or are phasing out inpatient services. The four facilities affected are: Naval Regional Medical Clinic, Annapolis, Md.; Naval Regional Medical Clinic, Port Hueneme, Calif.; Naval Regional Medical Clinic, Key West, Fla.; and Naval Regional Medical Clinic, Quantico, Va. Steps are underway to consolidate the clinic functions remaining at these facilities and turn vacated buildings back to the host commands where they are located.

## **CHAMPUS UNVEILS REVIEW PROGRAM FOR MENTAL HEALTH CARE**

A pioneering program designed to protect both patients and the government from paying for mental health care that is not appropriate for the condition being treated has been unveiled by CHAMPUS officials.

Individual cases will be examined by panels of psychiatrists or psychologists (depending on the treatment involved), and CHAMPUS payments will be ended for any care a panel determines to be inappropriate.

CHAMPUS officials enlisted the aid of the American Psychiatric Association and the American Psychological Association in developing standards for determining appropriateness and in establishing review procedures. These two professional organizations have also identified individuals who will serve on the panels.

Involvement of the two organizations adds a new dimension to the long-standing CHAMPUS effort to protect beneficiaries from paying for mental health care that is not appropriate for their problem. This is the first time that national mental health professional organizations have been involved in establishing standards of appropriateness and a review program.

The first reviews are already under way. Eventually, all outpatient mental health care that extends beyond a few visits and any institutional mental health care that goes beyond a few days will be reviewed. The only exception will be care received in a residential treatment center which must be authorized by OCHAMPUS before it is started.

## **MEDICO-LEGAL FEEDBACK—VIDEO TAPES ON MEDICINE AND LAW**

The VA, in conjunction with the American College of Legal Medicine, has recently produced a series of six video cassettes entitled "Current Problems in Medicine and the Law." The six subtitles of this series are (1) An Overview; (2) Professional Duty to the Patient; (3) Patient Injury Prevention; (4) The Medical Record; (5) When a Claim is Filed; and (6) Defense of a Law Suit. Each cassette runs 15-20 minutes. A set of the tapes has been provided to BUMED (001B), and it is available for loan to any command wishing to use it for staff meetings, officer indoctrination, and the like. The tapes can be used for individual viewing; however, greater benefit will be gained by group presentations followed by discussion of the various issues presented. A Navy Judge Advocate could be requested to assist in leading the discussion. (Commands that do not have a Staff Judge Advocate on board may coordinate with the local Naval Legal Service Office.) While the series was prepared for the use within the milieu of the VA, most of the information has application to all Federal health care delivery systems, and much of it is applicable to the non-Federal sector as well. To heighten the series' usefulness, the VA plans to publish study guides and quiz material to accompany each cassette. These will be made available upon receipt. To borrow the tapes, write MED 001B or call Autovon 294-4388.

## **TEMAC PROGRAM**

The FY79 TEMAC program for Medical Corps officers which was organized by COMNAVAIRLANT was extremely successful. Of the 90+ TEMAC billets which were authorized this fiscal year, all positions were filled. Next fiscal year the Medical Corps TEMAC program will be under administrative control of the Bureau of Medicine and Surgery. Individual medical officers who participated in the program this year are more than welcome to participate during FY80. Those officers interested in the FY80 program may contact the office of the Special Assistant for Naval Reserve, BUMED (MED 02D). Facility/activity locations and desired dates will be promulgated sometime in late August or early September. We expect to give at least six months lead time so that medical officers can prearrange leaves of absence from their practices.

U.S. NAVAL PUBLICATIONS and FORMS CENTER  
ATTN: CODE 306  
5801 Tabor Avenue  
Philadelphia, Pa. 19120  
Official Business

POSTAGE AND FEES PAID  
DEPARTMENT OF THE NAVY  
DoD-316



CONTROLLED CIRCULATION RATE

### SUBSCRIPTIONS AVAILABLE

U.S. NAVY MEDICINE is now available by subscription. Supporters of Navy medicine who are not eligible for free distribution, or who want their copy sent to their home address may order a personal

subscription through the U.S. Government Printing Office. Subscription rates are \$11 per year (12 issues) to addresses within the U.S., and \$14 per year to foreign addresses.

-----  
Enter my subscription to U.S. NAVY MEDICINE.—\$11.00 domestic mailing—\$14.00 foreign mailing. (Subscription rates include postage and handling costs. Make checks payable to Superintendent of Documents.)

Send Subscription to:

NAME—FIRST, LAST																													
COMPANY NAME OR ADDITIONAL ADDRESS LINE																													
STREET ADDRESS																													
CITY															STATE					ZIP CODE									

MAIL SUBSCRIPTION FORM TO:  
Assistant Public Printer  
(Superintendent of Documents)  
Government Printing Office  
Washington, DC 20402

PLEASE PRINT

U.S. NAVY MEDICINE